SYNOD of the Pacific ENROLLMENT FORM November 1, 2010 – October 31, 2011

Please review instructions for each company and coverage type BEFORE completing this form.

Church/Org Name _____
Location (ie: City/State)_____

___New Hire Date: _____
___Re Hire Date: _____
___Plan Change
___Open Enrollment
___Change Address
___Name Change New Name: _____
___Loss of Prior Coverage
___Add/Delete Dependent
___Part Time to Full Time Date: _____
___Other Date: _____

Effective Date _____/____/_____
Month Day Year

Employee/Subscriber Information

Social Security Number _____-_____-_____
Last Name _____
First Name _____
Middle Initial _____
Home Address _____
City _____
State _____
Zip _____
Gender ☐ Female ☐ Male
Marital Status ☐ Married ☐ Domestic Partner
☐ Single
Date of Birth _____/_____/_____
Month Day Year
Job Title _____
Hours Worked _____
Day Phone _____
Evening Phone _____
Email Address _____
Preferred Language _____

ANTHEM BLUE CROSS or KAISER PERMANENTE: Medical

☐ **PPO Anthem Blue Cross**
☐ **CA #165970M001** ☐ **BC #165970M007**
☐ **PPO Solutions 1 Anthem Blue Cross**
☐ **CA #165970M013** ☐ **BC # 165970M016**
☐ **HMO Anthem Blue Cross #165970H001**
☐ **HMO Plan – Kaiser Permanente**
☐ **N.CA #604931** ☐ **S.CA #230204** ☐ **NW #4575**
Enrollment Unit #_____
☐ **Decline Coverage (Reason):_____**

COVERAGE SELECTION
☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Spouse and Child(ren)

DELTA DENTAL: DENTAL #5986

☐ **Dental**
☐ **Decline Coverage (Reason):_____**

COVERAGE SELECTION
☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Spouse and Child(ren)

ANTHEM BLUE CROSS: BASIC TERM LIFE/AD&D #1659700001-2

☒ Employer Paid

VISION SERVICE PLAN: VISION #30010309

☐ **Vision and Medical**
☐ **Vision and Dental**
☐ **Vision Only**
☐ **Decline Coverage (Reason):_____**

COVERAGE SELECTION
☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Spouse and Child(ren)

Please fill out all sections if enrolling in Medical, Dental and/or Vision.

EMPLOYEE & FAMILY INFORMATION (Complete if electing or declining coverage)

Please list yourself and all eligible family members to be enrolled. Attach additional sheets if necessary.

	Last Name	First Name	MI	Social Security Number	Totally Disabled	If Children are age 19 or over, you must check the appropriate boxes below		Date of Birth	Anthem Blue Cross HMO Medical Group/ IPA Code	Anthem Blue Cross HMO IPA Primary Physician Code	Is this your current MD?
						Qualifies as IRS Dep	Full Time Student				
Self					N/A						Y N
Spouse Male Female					N/A						Y N
Domestic Partner Male Female					N/A						Y N
Son Daughter					Y N	Y N	Y N				Y N
Son Daughter					Y N	Y N	Y N				Y N
Son Daughter					Y N	Y N	Y N				Y N

OTHER HEALTH or DENTAL PLAN COVERAGE (Complete only if electing coverage)

	Has Other Health Coverage?	Has Other Dental Coverage?	Coverage Begin Date	Name and address of other carrier	Is this yours or your dependent's primary coverage
Self	YES NO	YES NO			YES NO
Spouse	YES NO	YES NO			YES NO
Domestic Partner	YES NO	YES NO			YES NO
Son Daughter	YES NO	YES NO			YES NO
Son Daughter	YES NO	YES NO			YES NO
Son Daughter	YES NO	YES NO			YES NO

PRIOR COVERAGE FOR PPO PLANS ONLY (Complete if electing coverage)

Please fill out the following information to receive credit for **PREVIOUS COVERAGE**. If immediately prior to becoming eligible for this plan, you or your dependents were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal law your employer or FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

	Names	Coverage Begin Date	Coverage End Date	Carrier Name	Reason for Ending Coverage
Self					
Spouse					
Domestic Partner					
Son Daughter					
Son Daughter					
Son Daughter					

Please complete if you want to decline Health/Dental coverage for yourself and/or any eligible dependents:

Reason for declining: (Proof of coverage may be required) Answers are for Med

☐ Covered by another employer-sponsored group plan; carrier name is: _____
☐ Covered by Individual Policy
☐ Covered by Medicare
☐ Covered by MediCal
☐ Enrolled in any other insurance carrier plan; name: _____
☐ Other: _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THIS GROUP'S MEDICAL AND/OR GROUP LIFE INSURANCE PLAN, as well as a six-month pre-existing condition exclusion UNLESS ENTITLED TO A SPECIAL ENROLLMENT PERIOD DUE TO CERTAIN CHANGED CIRCUMSTANCES (E.G., ACQUISITION OF A DEPENDENT OR LOSS OF OTHER COVERAGE THROUGH A DEPENDENT). I must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage). I have examined my options carefully before declining this coverage. I am aware that companies selling individual health insurance may require a review of my medical history that could result in a higher premium or I could be denied coverage.

FOR ANTHEM PARTICIPANTS ONLY: BASIC LIFE BENEFICIARY DESIGNATION: Unless otherwise specified, payment will be made to the primary beneficiary who survives the insured; if none, by all contingent beneficiaries who survive. The right to change the beneficiary is reserved unless otherwise noted. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designates as trustee, it is understood and agrees that Anthem Blue Cross Insurance Company shall not be a party to nor bound be the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to Anthem Blue Cross. If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.

Primary 1 (Last, First, Initial)	Relationship	Date of Birth	Social Security Number
Address of Primary Beneficiary (Street, City, State, Zip Code		Percentage:	
Primary 2 (Last, First, Initial)	Relationship	Date of Birth	Social Security Number
Address of Primary Beneficiary (Street, City, State, Zip Code		Percentage:	
Contingent 1 (Last, First, Initial)	Relationship	Date of Birth	Social Security Number
Address of Primary Beneficiary (Street, City, State, Zip Code		Percentage:	
Contingent 2 (Last, First, Initial)	Relationship	Date of Birth	Social Security Number
Address of Primary Beneficiary (Street, City, State, Zip Code		Percentage:	

Other (Estate of Insured, Revocable or Irrevocable Trust and Trustee under insured's will)	
	Percentage:

AUTHORIZATION: DELTA DENTAL

I understand that I may be required by the employer to pay for these benefits and those for my dependents. I agree to continue membership in the program selected above during employment and while the program is in force, I agree to comply with the terms of the group contract.

Employee Signature _____ Date _____

Explanation of Benefits reflecting claim payments for myself and my dependents will be sent to my home address. I also understand collection of social security numbers for myself and my dependents will be used by Principal Life only as allowed by law.

Applicable to all carriers
I understand that a copy of this form will be made available at my request and that it will be as valid as the original.
I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from the carriers listed on this form. I also understand collection of social security numbers for myself and my dependents will be used only as allowed by law.

Employee Signature _____ Date _____

AUTHORIZATION: To be signed by all employees applying for Kaiser Permanente coverage.

Kaiser Foundation Health Plan Arbitration Agreement:

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 1560.503-1), certain benefit-related disputes), any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Employee Signature _____ **Date** _____

Required for Kaiser Permanente HMO Plan

AUTHORIZATION: To be signed by all employees applying for Anthem Blue Cross coverage.

PLEASE READ CAREFULLY – SIGNATURE REQUIRED

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required dues.

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

EFFECTIVE DATE: The effective date of coverage is subject to Anthem Blue Cross approval.

REQUIREMENT FOR BINDING ARBITRATION

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. ***It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.*** **THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.**

Signature of Employee: _____ Date: _____

The information I have provided is, to the best of my knowledge, true and correct. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provision without written approval from the insurance carriers, on behalf of myself and my covered Dependents.

Employee/Subscriber Signature: _____ **Date:** _____/_____/_____